STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DING 00			(X3) DATE SURVEY COMPLETED			
11112 121111	or condition.	15C0001134	A. BUII B. WIN			07/06/2		
NAME OF P	ROVIDER OR SUPPLIER		D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
			1400 HIGHLAND RD STE 2					
	TOWER SPECIALTY SURGERY LLC			<u> </u>	OND, IN47374			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
S0000		,						
	This visit was for	a State licensure survey.	S0	000				
	Facility Number:							
	racinty ranioer.	001002						
	Survey Date: 7-5	5/6-11						
	Surveyors:							
	Jack I. Cohen, M							
	Medical Surveyo	r						
	John Lee, RN							
	Public Health Nu	irse Surveyor						
	QA: claughlin 0'	7/25/11						
	QA. Claughill 0	1/23/11						
S0310	410 IAC 15-2.4-2(a	a)(1)		•				
	The program shall have a written plar implementation that not limited to, the f	n of at evaluates, but is						
	(1) All services, in furnished by a con Based on docume	cluding services tractor. ent review and interview,	S0	310	The administrator is respons	ble	08/01/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XUKP11

Facility ID:

If continuation sheet

´		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15C0001134	A. BUILI	DING	00	07/06/2	
		1300001134	B. WING			0170072	011
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE GHLAND RD STE 2		
TOWER	SPECIALTY SURGE	ERY LLC			OND, IN47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL	P	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	for obtaining the documentat	ion	DATE
	_	to include 1 service			for the facility maintenace. Th		
		ontractor in its quality			has been obtained. This		
	•	rmance improvement			information will be added to t	he	
	(QAPI) program.				contracted services		
	Findings:				QAPI spreadsheet that is reported quarterly to the QA committee, medical staff, and	t	
	1 Review of the	facility's OAPI program			board of managers. The administrator will be responsi	ihle	
	Review of the facility's QAPI program indicated it did not include the contracted				to make certain that this repo		
	service of facility			ongoing and reported at each			
2. On 7-6-11 at 11:15 am, employee #A1,					quarterly meeting.		
	upon interview, indicated there was no						
	•	nd no documentation was					
	provided prior to						
	provided prior to	CAIL.					
S0328	410 IAC 15-2.4-2(I	b)					
	action to address t for improvement for	ound through the at and improvement					
	(1) The action mus (2) The outcome o documented as to continued follow-u patient care.	f the action must be its effectiveness,					
	the center failed to assessment progropportunity for in	ent review and interview, to ensure a quality ram that addressed the mprovement when it did of the Quality Assessment	S03	328	The administrator will make certain that in the future, all discussion regarding QA outcomes will be recorded in minutes. There was discussion what we were going to do improve this particular outcor	on to	08/01/2011

IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001134	(X2) MUL: A. BUILDI B. WING		00	(X3) DATE S COMPL 07/06/2 (ETED
			1400 HI	DDRESS, CITY, STATE, ZIP CODE GHLAND RD STE 2 DND, IN47374		
		I PR	1400 HI	GHLAND RD STE 2	the o. e o form s ts ere erator QA nutes is	(X5) COMPLETION DATE
above outcome a provide document response to not in The employee in	yee #A1 verified the nd was requested to ntation of action taken in neeting the above goal. dicated there was no nd none was provided					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001134		(X2) MU A. BUIL B. WINC	DING G	NSTRUCTION 00	(X3) DATE : COMPI 07/06/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE GHLAND RD STE 2		
TOWER	SPECIALTY SURG	ERY LLC			OND, IN47374		
(X4) ID		TATEMENT OF DEFICIENCIES	Ţ,	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCE		DATE
S1152	maintained in such safety and well-be assured as follows (3) Provision must periodic inspection maintenance, and physical plan and qualified personnes. (B) All mechanica (pneumatic, electrother) must be on maintenance schefrequency in accordance ptable standathe manufacturer's maintenance schefred acceptable standathe facility failed current preventive pieces of equipmers. 1. On 7-5-11 at was requested to of current PM or ventilation and a system. 2. On 7-6-7 at 3	of the physical rall center be developed and a manner that the rang of patients are series: It be made for the n, preventive repair of the equipment by a sofollows: It equipment ic, sterilizing, or a documented redule of appropriate rance with rards of practice or so recommended redule. In the provide evidence of the remaintenance (PM) on 2 ment. In the facility's heating, it conditioning (HVAC)	S11	152	It is the responsibility of the administrator to make certain all PM records for the facility HVAC system are document The PM records on the facilith HVAC system were obtained the building maintenance superviser and added to the ASC's PM log. This log will be presented to the Board of Managers at the next quarte meeting. The coffee maker's was updated as well. It, too, be presented at the next meeting.	ed. ty I from De rly S PM will	08/01/2011
		adicated there was no					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001134	A. BUILDI		NSTRUCTION 00	(X3) DATE S COMPL 07/06/2	ETED
	PROVIDER OR SUPPLIER			1400 HI	DDRESS, CITY, STATE, ZIP CODE GHLAND RD STE 2 DND, IN47374		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL I. S.C. IDENTIFYING INFORMATION	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION
TAG S1154	documentation of HVAC system. In provided prior to 3. On 7-6-11 at 1 of employee #A1 reception area the machine with a P12-31-06. At that requested to provided prior to 4. On 7-6-7 at 3: employee #A1 in documentation of coffee machine. In provided prior to 410 IAC 15-2.5-7(I) (b) The condition plant and the over environment must maintained in such safety and well-be assured as follows (3) Provision mus periodic inspection maintenance, and physical plant and qualified personne (C) Operational at control records must be assured as follows (3) Provision must periodic inspection maintenance, and physical plant and qualified personne (C) Operational at control records must be assured as follows (3) Provision must periodic inspection maintenance, and physical plant and qualified personne (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records must be assured as follows (C) Operational at control records (C) Operational at control records (C) Operational at control records (C) Operational at control recor	10:20 am, in the presence, it was observed in the ere was an electric coffee elected M sticker dated to time, the employee was ride documentation of the on the machine. 100 pm, upon interview, dicated there was not fourrent PM on the elected Mood Mood Mood Mood Mood Mood Mood Mo		TAG	DEFICIENCY)		DATE
	and analyzed at le These records mu available on the pr	st be readily					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	HITIPLE CO	ONSTRUCTION		MB NO. 0938-0391 E SURVEY
	N OF CORRECTION	IDENTIFICATION NUMBER:		00		COMPLETED	
		15C0001134	A. BUI			07/06/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLI	IER		1	IGHLAND RD STE 2	ž	
TOWER	SPECIALTY SUR	GERYLLC			OND, IN47374		
					1		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION	(X5) COMPLETION
TAG	`	ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
IAG	+	<u> </u>	C1	154	The administrator has o	htained	08/01/201
		ment review and interview,	51	134	the HVAC and fire alarm		08/01/201
	1	ed to document operational			manufacturer's recomme	•	
		ce control records for the			for preventive maintena		
		ation, and air conditioning			been verified that the pr		
	1 ` ′	re alarm systems being			maintenance currently de these systems is being of		
	analyzed at lea	st triennially.	accordance with policy/scl				
					and meet the acceptable		
	Findings:				standards or proctice. It	will be	
					the responsibility of the		
	1. On 7-5-11 a	at 10:30 am, employee #A1			administrator to present recommendations to the		
	was requested	to provide documentation			of managers at the upco		
	of triennial ana	alysis of HVAC and fire			board of managers mee		
	alarm systems	to determine the preventive			triennially thereafter.	-	
	maintenance co	onducted was in accordance					
	with the manuf	facturer's recommendation					
	or facility police	ev.					
	2 On 7-6-11 a	at 3:00 pm, upon interview,					
	1	indicated there was no					
	1 * *						
	documentation of triennial analysis of HVAC and fire alarm systems. No						
	documentation	was provided prior to exit.					
	I		I		I		I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XUKP11 Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	(3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
		15C0001134	B. WING			07/06/2	011	
			D. (111)		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				GHLAND RD STE 2			
	SPECIALTY SURGI	ERY LLC			OND, IN47374			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
S1164	410 IAC 15-2.5-7(b)(4)(B)(ı)						
	(b) The condition plant and the over environment must maintained in such safety and well-be assured as follows (4) The patient care to environments are as (B) All patient care be in good working serviced and main (i) All patient care be on a document schedule of appropaccordance with a of practice or their recommended ma Based on document facility failed maintaining 1 pie according to faci. Findings: 1. Review of a facility failed maintaining 1 pie according to faci. Findings: 2. Review of a facility failed test energy discharge their test energy disc	of the physical all center be developed and n a manner that the ing of patients are s: are equipment as follows: e equipment must g order and regularly ttained as follows: equipment must ed maintenance priate frequency in cceptable standards manufacturer's intenance schedule. ent review and interview, to document ece of equipment lity policy. acility policy entitled h Cart Cleaning and indicated the Nurse will unit [defibrillator] and arge. acility document entitled DR CHECKLIST, April,	S1	164	The Defibrillator Checklists h been reviewed with the staff. staff knows that is the ASC is closed, to mark "closed" on the particular day since the defibrillators will only be checon the days that surgeries an performed. It will be the responsibility of the administration make certain that the staff filling in the checklists accurate.	The shat cked e rator is	07/07/2011	
	2011, indicated t	he weekdays of April 18						

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001134	A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/06/2011
	PROVIDER OR SUPPLIER		1400	ET ADDRESS, CITY, STATE, ZIP CODE O HIGHLAND RD STE 2 HMOND, IN47374	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	E COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	entry and/or pers	and Tuesday) had no on's initial indicating brillator and testing the :			
	employee #A1 in not schedule pati closed the above- requested to prov documentation in had been charged	3:00 pm, upon interview, adicated the facility did ents on Fridays, was not estated days and was wide any other adicating the defibrillator d and tested. No further was provided prior to exit.			
S1166	safety and well-be assured as follows (4) The patient carrequirements are a (B) All patient carrbe in good working serviced and main (ii) There must be	of the physical all center be developed and n a manner that the ing of patients are s: are equipment as follows: e equipment must g order and reqularly tained as follows:			
	Based on docume failed to provide	ent review, the facility evidence of current enance (PM) on 2 pieces juipment.	S1166	The two pieces of patient of equipment that did not have current PM, were PM'd on 7/28/2011. These PMs will presented to the Board of Managers at the next meet	e a be

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001134	(X2) MUI A. BUILI B. WING	DING	OO	(X3) DATE S COMPL 07/06/20	ETED
	ROVIDER OR SUPPLIER SPECIALTY SURGI			1400 HIG	DDRESS, CITY, STATE, ZIP CODE BHLAND RD STE 2 ND, IN47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	was requested to of PM on a patient wheelchair.	10:30 am, employee #A1 provide documentation and stretcher, bed and a			and annually thereafter. It will the responsibility of the administrator to make certain these PMs are performed on yearly basis and reported to the Board.	that an	
current documenta above-two pieces of		dicated there was no tation of PM on the sof equipment. No ras provided prior to exit.					
S1168	1168 410 IAC 15-2.5-7(b)(4)(B)(iii) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:						
	(4) The patient carequirements are a(B) All patient care be in good working serviced and main	as follows: e equipment must g order and regularly					
	least triennially. Based on docume	equipment	S11	68	The administrator has obtained the manufacturer's	ed	08/01/2011

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPL	
		15C0001134	A. BUI B. WIN	LDING IG		07/06/2	011
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>	P. WII		DDRESS, CITY, STATE, ZIP CODE		
				1	GHLAND RD STE 2		
	SPECIALTY SURG			<u> </u>	OND, IN47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	preventive maint	tenance (PM) for 11			recommendations for elever		
	pieces of patient	care equipment being			pieces of patient care equiparties. The PM performed on these		
		triennially to ensure the			pieces of equipment has be		
		ned the manufacturer's			done in accordance with the	se	
	recommendation	for PM.			recommendations. This alor with the PM for each piece of		
	Findings:				equipment will be presented the next Board of Manager's	at	
	1 On 7-5-11 at	10:30 am, employee #A1			meeting. It will be the responsiblity of the administ	rator	
		provide documentation			to make certain that the PM	and	
	*	ysis of an anesthesia			manufacturer's recommenda will be presented triennially	ations	
	machine, defibri	llator, EKG machine,			thereafter to the Board of		
	emergency call ((code) system, overhead			Managers.		
	. •	swing light, patient					
	stretcher (bed), r	radiology equipment,					
	-	n machine, surgical table					
		to determine the PM					
		n accordance with the					
		ecommendation or facility					
	policy, as approp	onate					
	2. On 7-6-11 at	3:00 pm, upon interview,					
		ndicated there was no					
		of triennial analysis of the					
		t. No documentation was					
	provided prior to						